Health Maintenance Organizations

Health Maintenance Organizations Contents

Introduction

What are my Choices?

Your health plan options for 2005 are the State Health Plan (see pages 5-50 for details), traditional Health Maintenance Organizations (HMO) plans, an HMO with Point of Service (POS) option and the TRICARE Supplement plan (see pages 67-70 for details). The State Health Plan and the TRICARE Supplement are offered statewide. However, not all HMOs are available in all counties. Active employees must live or work in an HMO's service area to enroll in its plan. Retirees, COBRA subscribers and survivors must live in an HMO's service area to enroll in its plan.

These HMOs are available for 2005:

- Companion HMO
- CIGNA HMO
- MUSC Options

Traditional HMO

A plan in which subscribers must see only healthcare providers, including hospitals, within the HMO's network. If you receive care outside of this network, the HMO will not pay benefits unless the care was pre-authorized or deemed an emergency. You must choose a primary care physician (PCP), who coordinates your healthcare. To receive benefits when you see a specialist, you must first receive a referral from your PCP.

Point of Service (POS) Plan

A POS plan is an HMO plan that allows you to go to a provider inside or outside of its network. To receive the maximum level of benefits, care must be obtained from providers, including hospitals, within the HMO's network and be authorized by the HMO. When you use out-of-network services, you are likely to have much higher out-of-pocket expenses in the form of deductibles and copayments. The only HMO with POS is MUSC Options, which is available only in Berkeley, Charleston, Colleton and Dorchester counties.

Worksite Screening

If Companion HMO, CIGNA HMO or MUSC Options is your primary health plan, you may participate in a worksite screening sponsored by Prevention Partners. For a fee of $15, you will receive a comprehensive health appraisal that includes a blood test and an evaluation of your risk factors. Check with your benefits administrator to learn when a screening is scheduled in your area.

2005 Health Plan Service Areas

	COUNTY	HMO CHOICES
1	Anderson, Greenville, Oconee, Pickens	Companion HMO, CIGNA HMO
2	Cherokee, Spartanburg, Union	Companion HMO, CIGNA HMO
3	Chester, Lancaster, York	Companion HMO, CIGNA HMO
4	Abbeville, Greenwood, Laurens, McCormick, Saluda	Companion HMO
5	Fairfield, Kershaw, Lexington, Newberry, Richland	Companion HMO, CIGNA HMO
6	Aiken, Barnwell, Edgefield	Companion HMO
7	Allendale, Bamberg, Calhoun, Orangeburg	Companion HMO, CIGNA HMO
8	Clarendon, Lee, Sumter	Companion HMO, CIGNA HMO
9	Chesterfield, Darlington, Dillon, Florence, Marion, Marlboro, Williamsburg	Companion HMO, CIGNA HMO
10	Georgetown, Horry	Companion HMO, CIGNA HMO
11	Berkeley, Charleston, Colleton, Dorchester	Companion HMO, CIGNA HMO, MUSC Options
12	Beaufort, Hampton, Jasper	Companion HMO, CIGNA HMO

HMO Descriptions

A brief description of each HMO is included in this guide. If you wish to use specific physicians, hospitals and other healthcare providers, it would be best to check to see if they are part of the network of the HMO you are considering.

Please refer to the section beginning on page 211 for HMO premiums and a comparison of benefits. For more information, active employees should contact their benefits administrator, the HMO or EIP. Retirees, COBRA subscribers and survivors should contact the HMO or EIP for additional information. Telephone numbers and Web sites are listed on the inside cover of this book.

Companion HMO

Companion HealthCare administers Companion HMO, a traditional HMO that is offered statewide.

Primary Care Physician

At enrollment, you select a primary care physician (PCP) from Companion's statewide network. This physician coordinates all health services covered under your plan. When you need to see a specialist or other healthcare professional, your PCP will refer you to a network provider. You will receive an authorization stating what services are approved. Companion will then cover those healthcare services according to your group's plan.

Each member of your family may select a different PCP. Women may go to a participating gynecologist twice a year without a referral from the primary care physician. Additional visits require approval. Women also may go to a participating obstetrician for prenatal care.

PCPs in the Companion network are available to you 24 hours a day, seven days a week. If your personal doctor is not available, he will arrange for another doctor to take care of you.

Network Benefits

With Companion HMO, you receive benefits for covered services **only** when you go to participating physicians, hospitals and other healthcare providers. Network providers will:

- File covered expense claims for you
- Ask you to pay only the deductible, copayment and coinsurance amounts, if any, for covered expenses and
- Accept the plan's payment as payment-in-full for covered expenses, minus the copayment or coinsurance, if any

Deductible

As of Jan. 1, 2005, Companion has an annual deductible of $250 for individuals and $500 for families. The deductible applies to inpatient, outpatient and emergency professional services, including those provided by physicians and therapists, at hospitals; to admission to skilled nursing facilities; and to other services, including ambulances, durable medical equipment, hospice care and home healthcare. After the deductible is satisfied, coinsurance of 10 percent of the cost of the services will apply.

The deductible does not apply to office visits to primary care physicians and specialists, to retail and mail-order pharmacy benefits, to specialty drugs, to routine physicals, to mammograms and to well child care and immunizations.

Copayments

Copayments, the amount you pay when you receive services, vary depending on the type of care you receive. Companion's annual deductible does not apply to these services. The copayments are:

- $15 PCP per office visit
- $15 OB/GYN well-woman exam (women may self-refer to a contracting gynecologist twice a year)
- $25 specialist per office visit
- $35 urgent care per visit
- $200 per inpatient hospital admission
- $75 outpatient services for the first three hospital visits
- $100 emergency room visit
- $200 per hospital admission for inpatient mental health and substance abuse care
- $25 outpatient mental health and substance abuse office visit

Coinsurance

You are responsible for paying 10 percent of the cost of network hospital and emergency services after you meet your deductible.

Coinsurance Maximum

After you spend either $1,500 (individual coverage) or $3,000 (family coverage) out of your pocket in a year for network services, the plan will pay 100 percent of your medical costs for network services the remainder of the year. Copayments do not count toward your out-of-pocket limit or deductible.

Prescription Drugs

Companion HMO also provides prescription drug coverage. You **must** use a participating pharmacy (or mail service) when purchasing your medications. Benefits are not payable if you use a non-participating pharmacy. Copayments for up to a 31-day supply are:

- $8 for generics
- $25 for preferred brands
- $40 for non-preferred brands
- $75 specialty pharmaceuticals

Mail-order service for up to a 90-day supply is also available. The copayments are:

- $16 for generics
- $50 for preferred brands
- $80 for non-preferred brands

Generics First

If a participating physician prescribes a brand-name drug and says that substitution is permitted and an equivalent generic drug is available, and you request the brand-name drug, any difference between the cost of the brand-name drug and the generic drug is your responsibility. This will be in addition to the copayment for the brand-name drug. You will never be charged more than the actual retail cost of the drug.

Out-of-Network Benefits

Companion HMO covers emergency services by out-of-network providers. If you have a life- or limb-threatening illness or injury, please go to the nearest hospital or treatment center, whether or not it is in the network. You or a family member should tell your primary care physician and Companion HMO about the emergency as soon as possible.

If you live out-of-state for more than 90 days, you are eligible for Companion's Away from Home Care. It is usually possible to set up a guest membership in an HMO in the community where you are living. However, it can take several weeks to make arrangements. If you need the Away from Home Care program, do not delay in contacting the coordinator through Companion Member Services at 803-786-8476 (Columbia area) and 800-868-2528 (toll-free outside the Columbia area).

If you are living in a state other than South Carolina for fewer than 90 days or if you are traveling overseas, you may receive treatment from providers that are part of the BlueCard Program. For more information, see page 20 or visit www.bluecard.com

To be eligible for benefits, you must receive all other covered services from network physicians.

Other Plan Features

Companion HMO has worked with network physicians to develop programs that may help you make lifestyle changes that could improve your health. Best of all, these programs are offered either free or for a small, one-time fee. Topics include healthy mom and baby, healthy hearts, diabetes control, weight management and smoking cessation. For more information on these programs, call the Health Management department at 800-327-3183, ext. 25541. You also can visit Companion's Web site at www.companionhealthcare.com.

Other plan features include:

- **Vision care.** One exam for glasses per year (contact lens exam and fitting is extra); glasses from designated selection every two years or you can receive credit toward the purchase of contacts. Not all providers participate, and you must use a participating provider.
- **Natural Blue** offers special savings on health and wellness products such as acupuncturists, massage therapists, laser vision correction, vitamins and herbal supplements, books and tapes.

Claims

When receiving network care, your PCP or other participating provider will file your claims for you. If you receive out-of-network emergency care, you may have to pay fees out of your pocket. For information on the claims process, call Companion's Member Services Department at 803-786-8476 (Columbia area) and 800-868-2528 (toll-free outside the Columbia area).

Appeals

If you have a complaint, grievance or suggestion, Companion wants to know. Contact the Member Services department at 803-786-8476 (Columbia area) and 800-868-2528 (outside the Columbia area). If you prefer, you may write to :

Companion HealthCare
Member Services Department
P.O. Box 6170
Columbia, SC 29260-6170

You also can e-mail Companion HMO through the Web site at www.companionhealthcare.com.

If your complaint is about the quality of care you received, Companion will start a formal investigation through the quality management department. You must send all claims, questions or appeals within six months after you received the service.

If you have a question about an authorization, you must notify Companion within six months from the date authorization was approved or denied. If you do not contact Companion within six months, the decision will be considered final.

If you or your designated representative appeals, you have access to internal and independent external organization review levels. The internal review is a one-level review that includes panel review by individuals not involved in the original decision.

For medical necessity appeals, actively practicing physicians of the same or similar specialty will perform the review. Benefits appeals and provider appeals are eligible only for internal review. All member appeals are completed, including member notification of the decision, within 30 days of receipt by Companion.

If you are still dissatisfied after Companion HealthCare has reviewed its decision, you may ask the Employee Insurance Program (EIP) for a review by making a written request to EIP within 90 days of notice of Companion's denial. If EIP's Appeals Committee upholds the denial, you have 30 days to seek review in the circuit court pursuant to S.C. Code Ann. 1-23-380 (Law. Co-op. 1986 & Supp. 2001).

If you need more information about the appeal process, please call Companion HealthCare Member Services at 803-786-8476 (Columbia area) or 800-868-2528 (toll-free outside the Columbia area).

CIGNA HMO

CIGNA HMO, a traditional HMO plan administered by CIGNA HealthCare, is available in all counties in the state **except**: Abbeville, Aiken, Barnwell, Edgefield, Greenwood, Laurens, McCormick and Saluda.

Primary Care Physician

With CIGNA HMO, your primary care physician (PCP) is your first and primary source of medical care. The PCP you choose coordinates your medical care, including checkups, referrals to specialists, lab and X-ray services and hospital admissions.

When you enroll in CIGNA HMO, you and each covered member of your family chooses his or her own PCP. A woman may select an OB/GYN in addition to her PCP. A PCP can be a family/general practitioner, internist or pediatrician. PCPs are available to you 24 hours a day, seven days a week. If your personal doctor is not available, he will arrange for another doctor to take care of you.

Network Benefits

With CIGNA HMO you normally receive benefits for covered services **only** when you receive those services from participating physicians, hospitals and other healthcare providers. Network providers will:

- File claims for covered expenses for you
- Ask you to pay only the copayment and coinsurance amounts, if any, for covered expenses

Copayments

Copayment amounts vary depending on the services you receive. The CIGNA HMO plan has no annual deductible. Copayments for doctor and hospital services under the plan are:

- $20 PCP office visit
- $40 OB/GYN visit
- $40 specialist office visit
- $500 per inpatient hospital admission
- $250 outpatient surgery and medical care
- $100 emergency care
- $500 per admission for inpatient mental health and substance abuse care
- $40 outpatient mental health and substance abuse office visit

Coinsurance

You are responsible for 20 percent of the cost of hospital services by network providers in addition to the copayments. Emergency room services are covered at 100 percent after the copayments.

Coinsurance Maximum

Once you have spent either $3,000* (individual coverage) or $6,000* (family coverage) out of your pocket in a year for network services, the plan will pay 100 percent of your covered medical costs for the rest of the year. ***Inpatient and outpatient copayments and coinsurance count toward your out-of-pocket maximum. However, other copayments do not.**

Prescription Drugs

The CIGNA plan provides prescription drug coverage. With CIGNA HMO, you **must** use a participating pharmacy (or mail service) when purchasing your medications. Benefits are not payable if you use a non-participating pharmacy. Copayments for up to a 30-day supply are:

- $7 for generics
- $25 for preferred brands
- $50 for non-preferred brands.

CIGNA HMO offers an online prescription center (CIGNA TelDrug) that allows you to order prescriptions and refills for home delivery, review the list of covered drugs and check the status of a recent order 24 hours a day. The copayments for up to 90-day supply are:

- $14 for generics
- $50 for preferred brands
- $100 for non-preferred brands.

Out-of-Network Benefits

You may receive emergency services from out-of-network providers. If you have a life- or limb-threatening illness or injury, please go to the nearest hospital or treatment center, whether or not it is in the network. We do ask that you or a family member tell your primary care physician and CIGNA HMO about the emergency as soon as possible.

Enrolled dependents who are living in a state other than South Carolina are eligible for "Guesting," a guest membership in an HMO in the community where they live, for up to two years. Call 800-244-6224 to be set up with a provider network away from home. When they return home, they can switch back to the South Carolina network.

Other Plan Features

Other special features of the CIGNA plan include:

- **The CIGNA 24-Hour Health Information Line**SM that provides access to medical information, level-of-care counseling, an audio library of hundreds of topics and guidance to network providers.
- The **Healthy Rewards** program that includes special offers for discounts on health-related products and services.
- **Vision care.** Subscribers receive a $10 eye exam every two years. Not all providers participate, and you must use a participating provider.
- **Nationwide access** to specially trained experts and nationally recognized facilities through the CIGNA LIFESOURCE Organ Transplant Network.

Claims

There's no paperwork for network care. Just show your CIGNA plan ID card and pay your copayment. Your provider will complete and submit the paperwork. If you visit an out-of-network provider, you or your provider must file a paper claim. You will receive an Explanation of Benefits identifying the costs covered by your plan and the charges you must pay. For more information on the claims process, please contact CIGNA HealthCare at 800-244-6224.

Appeals

These steps must be followed if you have a concern or an appeal:

- Call or write CIGNA's Member Services Department, and a representative will work with you to resolve your concern.
- If it is not resolved to your satisfaction, you may appeal the decision to CIGNA's Appeal Committee. This is called a Level One Appeal. The Appeal Committee will notify you in writing of its decision within 30 calendar days.
- If you do not agree with the decision, you may appeal to CIGNA's Grievance Committee. This is a Level Two Appeal. The Grievance Committee will notify you in writing of its decision within 30 calendar days.

If you are still dissatisfied after CIGNA HealthCare has reviewed its decision, you may ask EIP to review the matter by making a written request to EIP within 90 days of notice of the denial. If the EIP Appeals Committee upholds the denial, you have 30 days to seek review in the circuit court pursuant to S.C. Code Ann. 1-23-380 (Law. Co-op. 1986 & Supp. 2001). For more information on the appeals process, please contact CIGNA HealthCare at 1-800-244-6224, or write CIGNA HealthCare at P.O. Box 5200, Scranton, PA 18505.

MUSC Options

Introduction

MUSC Options is a self-insured, Point of Service plan that is administered by Companion HealthCare and Medco. Permanent, full-time, state-covered employees who live or work in Berkeley, Charleston, Colleton or Dorchester counties are eligible to enroll. The plan is also available to retirees who are not eligible for Medicare, survivors and COBRA subscribers who live in this area.

Primary Care Physician

When you enroll in MUSC Options, you select a primary care physician (PCP). Your PCP may practice internal medicine, family medicine or pediatrics. All medical services must be authorized in advance by your PCP and/or Companion HealthCare (the plan administrator) to receive the highest level of benefits. Each member of your family may select a different PCP.

Referrals

If you need to see a specialist, your PCP will refer you to one who participates in the MUSC Options network. You may self-refer to a specialist. However, a higher percentage of your costs will be paid if your PCP refers you.

Copayments

The copayments for doctor and hospital services received within the MUSC Options network are:

- $15 PCP per office visit
- $15 OB/GYN well-woman exam (two self-referred visits a year)
- $25 specialist per office visit with referral
- $45 specialist per office visit without referral
- $35 urgent care visit
- $300 per inpatient hospital admission
- $100 per outpatient hospital visit (There is a maximum of three copayments per year. However, there is no outpatient hospital visit copayment for services performed at a Medical University of South Carolina outpatient facility.)
- $100 emergency room per visit

Prescription Drug Program

MUSC Options Prescription Drug Program, administered by Medco, is easy and convenient to use. You simply show your MUSC Options identification card when you purchase prescription drugs from a participating pharmacy and pay these copayments for up to a 31-day supply:

- $10 for generic drugs
- $25 for preferred brand drugs
- $40 for non-preferred brand drugs

A 90-day supply of a prescription may be ordered by mail. Copayments are:

- $15 for generic drugs
- $50 for preferred brand drugs
- $80 for non-preferred brand drugs

"Pay-the-Difference"

If a generic drug is available and you purchase the brand-name version instead, the benefit will be limited to the cost of the generic drug. You will be responsible for paying the difference.

MUSC Options participates in the Select Rx Network, Medco's pharmacy network. For a list of participating providers, go to www.medco.com. Remember, you **must** use a participating pharmacy or mail service and you **must** show your ID card when purchasing medications. **Benefits are not payable if you use a non-participating pharmacy.**

Coordination of Benefits

On January 1, 2005, MUSC Options began coordinating prescription drug benefits. This provision is not new to subscribers. MUSC Options already coordinates medical benefits when subscribers are covered by more than one insurance company. By doing so, it makes sure you are not reimbursed more than once for the same expense and that each company pays its fair share of the cost of your care.

When you are covered by more than one plan, the plan that pays first is the *primary* plan. The *secondary* plan pays after the primary plan. MUSC Options determines which plan is primary. Here are some examples of how that works:

- The plan that covers a person as an employee is primary to the plan that covers the person as a dependent.
- When both parents cover a dependent child, the plan of the parent whose birthday comes earlier in the year is considered primary.

When filling a prescription at a participating pharmacy, you may notice a difference in the amount MUSC Options pays.

If MUSC Options is primary:
When you purchase a prescription, present your MUSC Options insurance card first. Your claim will be processed under the plan as if you had no other coverage. Then present the card for your secondary insurance coverage. If the pharmacy can pay secondary insurance claims electronically, benefits under that plan will be paid.

If MUSC Options is secondary:
Present the card for your primary coverage first. If you present your MUSC Options card first, the claim will be initially denied because the MUSC Options is secondary. After the pharmacy processes the claim through your primary coverage, it will be processed through MUSC Options.

If the pharmacy cannot process secondary insurance claims electronically, the claim may be rejected. If this happens, you will need to file a paper claim for any MUSC Options benefits to Medco. Prescription drug claim forms are available through the EIP Web site at www.eip.sc.gov. Choose your category and then select "Forms." You will see both the retail and pharmacy mail service/home delivery forms listed.

Please remember: MUSC Options is not responsible for filing or processing claims for a subscriber through another health insurance plan. That is your responsibility.

Vision Care The plan pays up to $75 for a routine eye exam every year and up to $75 for eye wear once every other year. You may use any licensed vision care provider and then file a claim for reimbursement.

Out-of-Network Benefits

Benefits obtained outside the MUSC Options provider network are covered at 60 percent of allowable charges after an annual deductible. The annual deductible is $300 for single coverage and $900 for family coverage.

The annual out-of-pocket maximum is $3,000 for individual coverage and $9,000 for family coverage. After the annual out-of-pocket maximum is met, MUSC Options will pay 100 percent of allowable charges after the copayment for covered medical benefits for the rest of the year. Annual deductibles, copayments and charges above the plan's allowed charges do not contribute to your out-of-pocket maximums. **Certain benefits, such as preventive care and prescription drugs, are not covered out-of-network.**

How to File Claims

When you use a network provider, the network doctor or hospital will file your claim for you. If you use an out-of-network physician or hospital, you may have to file the claim yourself. You can get claim forms from your benefits office or from the Companion HealthCare Web site www.companionhealthcare.com. You must complete a separate claim form for each individual who received care. Mail the form to:

Companion HealthCare
MUSC Options Plan
Member Services Department
P.O. Box 6170
AX-435
Columbia, SC 29260-6170

Appeals If you have a complaint, grievance or suggestion, Companion HealthCare wants to know. Contact the Member Services department at 1-800-821-3023 or write to:

Companion HealthCare
Member Services Department
P.O. Box 6170
AX-435
Columbia, SC 29260-6170

You also can e-mail Companion HealthCare through the Web site at www.companionhealthcare.com.

If your complaint is about the quality of care you received, Companion HealthCare will start a formal investigation through the quality management department. You must send all claims, questions or appeals within six months after you receive the service. If you have a question about an authorization, you must notify Companion HealthCare within six months from the date authorization was approved or denied. If you do not contact Companion HealthCare

within six months, the decision will be considered final. As a Companion HealthCare member, you or your designated representative have access to internal and independent external organization review levels of appeal. The internal review is a one-level review that includes panel review.

For medical necessity appeals, actively practicing physicians of the same or similar specialty will review the decision. Benefits appeals and provider appeals are eligible only for internal review. All member appeals are completed, including member notification of the decision, within 30 days of receipt by Companion HealthCare. If you are still dissatisfied after Companion HealthCare has completed its review, you may request that EIP review the matter by making a written request to EIP within 90 days of the notice of the denial. If the EIP Appeals Committee upholds the denial, you have 30 days to seek review in the circuit court pursuant to S.C. Code Ann. 1-23-380 (Law. Co-op. 1986 & Supp. 2001). If you need more information about the appeal process, please call Companion HealthCare Member Services at 1-800-821-3023.